CLAIM FOR VISION CARE EXPENSE

NATIONAL VISION ADMINISTRATORS
division of National Prescription Administrators, Inc.
P.O. Box 1981 / East Hanover, N.J. 07936-1981
800-672-7723

Montgomery County Government

EMPLOYEE Please Complete This Section *(Print)*

LAST NAME | FIRST | CARD MEMBER S.S. NO.

STREET ADDRESS

CITY | STATE | ZIP

COMPLETE IF CLAIM FOR DEPENDENT

FIRST NAME	DATE OF BIRTH	SEX	STATUS
	/ /	☐ MALE ☐ FEMALE	☐ SPOUSE ☐ CHILD

MARITAL STATUS
☐ SINGLE ☐ MARRIED ☐ WIDOWED
☐ DIVORCED ☐ LEGALLY SEPARATED

IMPORTANT, I CERTIFY THAT THE PATIENT INFORMATION ENTERED ON THIS FORM IS CORRECT, THAT THE PATIENT NAMED IS ELIGIBLE FOR THE BENEFITS AND THAT I HAVE RECEIVED THE SERVICES DESCRIBED. I ALSO CERTIFY THAT THE SERVICES AND MATERIALS RECEIVED ARE NOT FOR AN ON THE JOB INJURY OR COVERED UNDER ANOTHER VISION PROGRAM. I FURTHER AUTHORIZE THE RELEASE OF ALL INFORMATION ON THIS FORM TO NVA, UNDERWRITER, SPONSOR, POLICY HOLDER AND THE EMPLOYER.

EMPLOYEE SIGNATURE _____ DATE _____

IS CLAIM CONNECTED IN ANY WAY WITH: 1) PATIENT'S OCCUPATION, ACCIDENT OR EYE SURGERY (OTHER THAN CATARACT SURGERY)? ☐ YES ☐ NO 2) SAFETY GLASSES? ☐ YES ☐ NO 3) CATARACT SURGERY? ☐ YES ☐ NO. IF ANY QUESTION ANSWERED YES, GIVE DETAILS AND DATES IN SPACE PROVIDED.

IS PATIENT COVERED UNDER ANY OTHER GROUP VISION PLAN FOR THE SERVICE(S) PRESENTED BELOW? ☐ YES ☐ NO. IF ANSWERED YES, GIVE INSURANCE COMPANY NAME, ADDRESS AND POLICY NUMBER IN SPACE PROVIDED.

TO BE COMPLETED BY EXAMINING OPHTHALMOLOGIST OR OPTOMETRIST *(Print)*

EXAMINER NAME | ☐ MD ☐ OD | TAX ID#

STREET ADDRESS

CITY | STATE | ZIP

I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES INDICATED HEREON.

SIGNATURE _____ DATE _____

PATIENT NAME | DATE OF EXAM

CAN VISUAL ACUITY BE RESTORED TO AT LEAST 20/70 IN THE BETTER EYE WITH CONVENTIONAL GLASSES? ☐ YES ☐ NO

DID PATIENT HAVE EYEGLASSES PRIOR TO YOUR EXAMINATION? ☐ YES ☐ NO

DOES PATIENT REQUIRE A PRESCRIPTION CHANGE? ☐ YES ☐ NO IF YES: CHANGES:

AXIS _____ SPHERE OR CYLINDER _____

SERVICE CHARGE $

I HAVE PRESCRIBED ☐ SINGLE VISION ☐ BIFOCAL ☐ TRIFOCAL ☐ APHAKIC ☐ CONTACTS ☐ HARD ☐ SOFT ☐ COSMETIC ☐ MEDICALLY REQUIRED

TO BE COMPLETED BY DISPENSER *(Print)*

DISPENSER NAME | TAX ID#

STREET ADDRESS

CITY | STATE | ZIP

I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES AND SUPPLIED THE MATERIAL INDICATED HEREON.

SIGNATURE _____ DATE _____

PATIENT NAME | DATE OF SERVICE

Rx	SPHERE	CYLINDER	AXIS	PRISM	ADD
RIGHT					
LEFT					

LENSES

U.S. MANUFACTURER NAME, FABRICATING LAB MODEL OR STYLE

TRADE NAME | WIDTH | ☐ PAIR ☐ ONE ☐ GLASS ☐ PLASTIC

FRAMES

MANUFACTURER | SIZE | MODEL OR STYLE

FRAME NUMBER | ☐ PLASTIC ☐ COMBINATION ☐ METAL | ☐ NEW ☐ PATIENTS

MATERIALS SUPPLIED	CHARGES	NVA USE
☐ SINGLE VISION		
☐ BIFOCAL		
☐ TRIFOCAL		
☐ APHAKIC		
☐ CONTACTS ☐ HARD ☐ SOFT		
☐ TINT #_____ COLOR_____		
☐ OTHER _____		
FRAME		
TOTAL CHARGE		

CLAIM INSTRUCTIONS

EMPLOYEE:

- Use this form to obtain reimbursement for services.
- Complete the employee section of the form.
- Sign and date the form after checking for completeness.
- Attach copy of itemized receipts.
- Submit the form to:

NATIONAL VISION ADMINISTRATORS
P.O. BOX 1981
EAST HANOVER, NEW JERSEY 07936-1981
TOLL FREE 800-672-7723
N.J. 973-503-1000

If you have any questions, please contact NVA at 800-672-7723.